U.S. Department of State

# MEDICAL EXAMINATION FOR IMMIGRANT OR REFUGEE APPLICANT

For use with TB Technical Instructions 2007 and the DS-3030

OMB No. 1405-0113
EXPIRATION DATE: 08/31/2014
ESTIMATED BURDEN: 10 minutes
*(See Page 2 - Back of Form)*

**Photo**

**Name** *(Last, First, MI.)* _____, _____, _____

**Birth Date** *(mm-dd-yyyy)* _____ **Sex:** ☐ **M** ☐ **F**

**Birthplace** *(City/Country)* _____ / _____

**Present Country of Residence** _____ **Prior Country** _____

**U.S. Consul** *(City/Country)* _____ / _____

**Passport Number** _____ **Alien** *(Case)* **Number** _____

**Date of Medical Exam** *(Date of TB physical exam or date of lab report of final TB culture results, if cultures performed) (mm-dd-yyyy)* _____

**Date Exam Expires** *(3 months if Class A TB, or Class B1 TB, otherwise 6 months) (mm-dd-yyyy)* _____

**Date** *(mm-dd-yyyy)* **of Prior Exam, if any** _____ **Exam Place** *(City/Country)* _____ / _____

**Panel Physician** _____ **Radiology Services** _____

**Screening Site** _____ **Lab** *(Name for syphilis/TB)* _____ / _____

## (1) Classification *(Check all boxes that apply):*

☐ **No apparent defect, disease, or disability** *(See Worksheets DS-3025, DS-3026, and DS-3030)*

☐ **Class A Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ TB, active, infectious *(Class A, from Chest X-Ray Worksheet)*
- ☐ Syphilis, untreated
- ☐ Chancroid, untreated
- ☐ Gonorrhea, untreated
- ☐ Granuloma inguinale, untreated
- ☐ Lymphogranuloma venereum, untreated
- ☐ Hansen's disease, untreated multibacillary
- ☐ Addiction or abuse of specific* substance
- ☐ Any physical or mental disorder *(including other substance-related disorder)* with harmful behavior or history of such behavior likely to recur

*amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B Conditions** *(From Past Medical History and Physical Examination Worksheets)*

- ☐ Syphilis *(with residual defect)*, treated within the last year
- ☐ Current pregnancy, number of weeks pregnant _____
- ☐ Any physical or mental disorder *(excluding addiction or abuse of specific* substance but including other substance-related disorder)* without harmful behavior or history of such behavior unlikely to recur
- ☐ Hansen's disease, treated multibacillary
  Treatment: ☐ Partial ☐ Completed
- ☐ Hansen's disease, paucibacillary
  Treatment: ☐ None ☐ Partial ☐ Completed
- ☐ Sustained, full remission of addiction or abuse of specific* substances

*amphetamines, cannabis, cocaine, hallucinogens, opioids, phencyclidines, sedative-hypnotics, and anxiolytics

☐ **Class B1 TB, Pulmonary**

- ☐ No treatment
- ☐ Completed treatment *(Check all that apply and attach all laboratory and DOT documents)*
  - ☐ By panel physician
  - ☐ Initial smear positive
  - ☐ Pre-treatment culture and DST results performed/available
  - ☐ By non-panel physician
  - ☐ Initial culture positive
  - ☐ Pre-treatment culture and/or DST results not performed/available

☐ **Class B1 TB, Extrapulmonary** Anatomic Site of Disease _____

- ☐ No treatment
- ☐ Current treatment
- ☐ Completed treatment

☐ **Class B2 TB, LTBI Evaluation**

- ☐ Test for TB infection positive: ☐ TST _____ mm; ☐ IGRA positive Result _____ ☐ TST or IGRA Conversion
  - ☐ No LTBI treatment
  - ☐ Current LTBI treatment *(Indicate medications in Part 4 of DS-2054 form)*
  - ☐ Completed LTBI treatment *(Indicate medications in Part 4 of DS-2054 form)*

## Class B Tuberculosis - Continued

☐ **Class B3 TB, Contact Evaluation**

☐ TST ____ mm ☐ IGRA negative ☐ IGRA positive IGRA Result _____

☐ No preventive treatment

☐ Current preventive treatment *(Indicate medications in Part 4 of DS-2054 form)*

☐ Completed preventive treatment *(Indicate medications in Part 4 of DS-2054 form)*

Source Case: Name _____

Alien Number _____

Relationship to Contact _____

Date Contact Ended *(mm-dd-yyyy)* _____

Type of Source Case TB *(Mark only one and **ATTACH DST RESULTS**)*

☐ Pansusceptible TB

☐ MDR TB *(resistant to at least INH and rifampin)*

☐ Drug-resistant TB other than MDR TB

☐ Culture negative

☐ Culture results not available

☐ **Class B Other** *(specify or give details on checked conditions from worksheets)* _____

_____

_____

_____

**(2) Laboratory Findings** *(check all boxes that apply):*

**Syphilis:** ☐ **Not done**

| | Test Name | Date*(s)* Run *(mm-dd-yyyy)* | Negative | Positive | Titer 1 | Notes |
|---|---|---|---|---|---|---|
| Screening | | | | | | |
| Confirmatory | | | | | | |

| Treated | If treated, therapy: | Date*(s)* treatment given *(mm-dd-yyyy) (3 doses for penicillin)* |
|---|---|---|
| ☐ Yes<br>☐ No | ☐ Benzathine penicillin, 2.4 MU IM<br>☐ Other *(therapy, dose)*: _____ | _____ _____ _____ |

**Test for Cell-Mediated Immunity to TB** *(Required for all applicants 2 through 14 years of age; perform one type only)*

☐ TST

Date Applied *(mm-dd-yyyy)* _____ Result *(mm)* _____

☐ IGRA

Name of IGRA Test _____ Date Drawn *(mm-dd-yyyy)* _____

Nil Value (IU/ml or number of cells) _____ TB Response *(TB- nil IU/ml or number of cells*)* _____

IGRA Interpretation: ☐ Positive ☐ Negative ☐ Indeterminate, Borderline, or Equivocal

* For T-Spot, TB Response number of cells = Higher of Panel A or Panel B minus nil value

**(3) Immunizations** *(See Vaccination Form, check all boxes that apply)* **Not required for refugee applicants.**

☐ Vaccine history complete

☐ Vaccine history incomplete, requesting waiver *(indicate type below)*

☐ Incomplete vaccine history, no waiver requested

☐ Blanket waiver ☐ Individual waiver

**I certify that I understand the purpose of the medical examination and I authorize the required tests to be completed.**

| Applicant Signature | Panel Physician Signature | Date *(mm-dd-yyyy)* |
|---|---|---|

**(4) Tuberculosis Treatment Regimen**

**(Fill out if applicant has taken in the past, or is now taking TB medication. If drug doses or dates not known or not available, mark "unknown".)**

☐ Check if therapy currently prescribed *(if current, don't mark "End Date")*

| Medication | Dose/Interval *(e.g., mg/day)* | Start Date *(mm-dd-yyyy)* | End Date *(mm-dd-yyyy)* |
|---|---|---|---|
| ☐ Isonaizid *(INH)* | | | |
| ☐ Rifampin | | | |
| ☐ Pyrazinamide | | | |
| ☐ Ethambutol | | | |
| ☐ Streptomycin | | | |
| ☐ Other, specify | | | |
| | | | |
| | | | |
| | | | |

Applicant's pre-treatment weight *(kg)* _____ Date *(mm-dd-yyyy)* _____

Remarks _____

## PAPERWORK REDUCTION ACT AND CONFIDENTIALITY STATEMENTS

**PAPERWORK REDUCTION ACT STATEMENT**

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time required for searching existing data sources, gathering the necessary documentation, providing the information and/or documents required, and reviewing the final collection. You do not have to supply this information unless this collection displays a currently valid OMB control number. If you have comments on the accuracy of this burden estimate and/or recommendations for reducing it, please send them to: A/GIS/DIR, Room 2400 SA-22, U.S. Department of State, Washington, DC 20522-2202

**CONFIDENTIALITY STATEMENT**

AUTHORITIES The information asked for on this form is requested pursuant to Section 212(a) and 221(d) and as required by Section 222 of the Immigration and Nationality Act. Section 222(f) provides that the records of the Department of States and of diplomatic and consular offices of the United States pertaining to the issuance and refusal of visas or permits to enter the United States shall be considered confidential and shall be used only for the formulation, amendment, administration, or enforcement of the immigration, nationality, and other laws of the United States. Certified copies of such records may be made available to a court provided the court certifies that the information contained in such records is needed in a case pending before the court.

PURPOSE The U.S. Department of State uses the facts you provide on this form primarily to determine your classification and eligibility for a U.S. immigrant visa. Individuals who fail to submit this form or who do not provide all the requested information may be denied a U.S. immigrant visa. Although furnishing this information is voluntary, failure to provide this information may delay or prevent the processing of your case.

ROUTINE USES If you are issued an immigrant visa and are subsequently admitted to the United States as an immigrant, the Department of Homeland Security will use the information on this form to issue you a Permanent Resident Card, and, if you so indicate, the Social Security Administration will use the information to issue a social security number. The information provided may also be released to federal agencies for law enforcement, counterterrorism and homeland security purposes; to Congress and courts within their sphere of jurisdiction; and to other federal agencies who may need the information to administer or enforce U.S. laws.